Medicare and Coordinated Care Plans

Medicare Beneficiaries Can Enroll in Health Maintenance Organizations and Other Types of Prepaid Plans

U.S. Department of Health and Human Services
Health Care Financing Administration

It's your choice!

As a Medicare beneficiary, you can choose how you will receive hospital, doctor and other health care services covered by Medicare. You can receive them either through the traditional fee-for-service (pay-as-you-go) delivery system or through coordinated care plans [health maintenance organizations (HMOs) and competitive medical plans (CMP's)] which have contracts with Medicare.

Whether you choose fee-for-service or coordinated care, you get all of Medicare's hospital and medical benefits. The differences in the two systems include how the benefits are delivered, how and when payment is made, and how much you might have to pay out of your pocket. This leaflet, while making brief mention of the fee-for-service system, is intended to provide a general explanation of the coordinated care option under Medicare. If you want more detailed information about the fee-for-service system and Medicare in general, refer to *The Medicare Handbook*. Copies are available from any Social Security Administration office.

How do the fee-for-service and coordinated care systems work?

Fee-for-Service Care: Under the fee-for-service payment system, you can choose any licensed physician and use the services of any hospital, health care provider or facility certified by Medicare. Generally, a fee is paid each time a service is used. While Medicare,

within certain limits, will pay a large portion of your hospital, physician and other health care expenses, you are liable for Medicare's deductibles and coinsurance amounts. You must also pay all permissible charges in excess of Medicare's approved amounts as well as charges for services not covered by Medicare. Some of these potential out-of-pocket costs can be avoided or reduced through the purchase of private insurance to supplement Medicare. It is called "Medigap" insurance and it is specifically designed to close some of the payment gaps in your Medicare coverage.

Coordinated Care Plans: In a coordinated care plan a network of health care providers (doctors, hospitals, skilled nursing facilities, etc.) generally offers comprehensive, coordinated medical services to plan members on a prepaid basis. Services usually must be obtained from the professionals and facilities that are part of the plan. Depending on the organization of the plan, the services are usually provided either at one or more centrally located health facilities or in the private practice offices of the professionals affiliated with the plan.

If you enroll in a coordinated care plan that has a contract with Medicare, a monthly payment is made to the plan by Medicare. In addition, most plans charge enrollees nominal copayments each time a service is used. Most plans also charge a monthly premium. It replaces the deductible and coinsurance amounts that you

would pay under the fee-for-service system but do not pay as a plan member. There usually are no additional charges no matter how many times you visit the doctor, are hospitalized, or use other covered services. In return, the plan provides you with all Medicare hospital and medical benefits available in the plan's area if you are enrolled in both Medicare Hospital Insurance (Part A) and Medicare Supplementary Medical Insurance (Part B). If you are enrolled only in Part B, your coverage would be limited to services covered by Part B. Some plans also provide benefits beyond what Medicare pays for, such as preventive care, prescription drugs, dental care, hearing aids and eyeglasses.

Why join a coordinated care plan?

People join coordinated care plans for several reasons. Some of the most frequently mentioned include:

- It's generally easier to get care through one source (for example, doctors' services, hospital care, laboratory tests, X-rays, etc.)
- Quality of care may be enhanced because of the coordination of services.
- You can more easily budget health care costs because you know the amount of any premiums in advance, and the total of other out-of-pocket expenses is likely to be less than under the fee-for-service system.

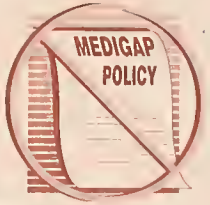
- You generally pay only a nominal copayment when you use a service. Some plans do not charge copayments for certain specified services.
- In many cases, benefits beyond those covered by Medicare are available at either no additional charge or a nominal charge.
- You will not need Medigap insurance to supplement your Medicare coverage because the plan provides you with all or most of the same benefits at no additional cost. Moreover, unlike Medigap insurers who in some cases can refuse to sell insurance to persons with a health problem, coordinated care plans generally must accept all Medicare applicants.

Are there any other factors to consider in deciding whether to enroll in a coordinated care plan?

Before enrolling, get information about the doctors available to serve you, the hospitals the plan uses, all auxiliary services and, if you travel frequently, your out-of-area coverage. Also, ask about services for any medical condition for which you are being treated, keeping in mind that you cannot be denied membership because of a pre-existing condition. It is also important that you determine whether the plan's providers are in a location convenient to you and whether transportation is available at all hours to get you to them.

Medigap insurance is another issue that you should consider if you are thinking about enrolling in a plan, or if you are already in a plan and are thinking about disenrolling. As a plan member, you will not need a Medigap

policy. In fact, insurers are prohibited from issuing you one because it would duplicate your benefits in violation Federal law. If, however, you have a Medigap policy and decide to enroll in a plan, you may keep the policy for a short time while you decide if you like the plan. Should you enroll in a plan and later decide to disenroll and return to the fee-for-service system, be aware that you may not be able to buy a Medigap policy on favorable terms, especially if you have a pre-existing health condition.



Can I enroll in a coordinated care plan?

Most Medicare beneficiaries are eligible for enrollment in a coordinated care plan, and most parts of the country are served by one or more plans that have Medicare contracts. In addition to being called coordinated care plans, they also are know as prepaid or managed care plans, or just HMOs or CMPs. Plans with Medicare contracts cannot screen their applicants to find whether they are healthy or delay coverage for a pre-existing condition. The only enrollment requirements are:

- You must at least be enrolled in Medicare Supplementary Medical Insurance (Part B) and continue to pay the Part B monthly premium. If you also have Medicare Hospital Insurance (Part A), and most beneficiaries do, the plan will provide both Medicare hospital and medical benefits.

The Part B monthly premium ($36.60 in 1993) is usually deducted from your Social Security or Railroad Retirement check. It is not the same as the monthly premium charged by most plans.

You must live within the area in which the plan has agreed to provide services;

- You cannot have elected care from a Medicare-certified hospice*; *and*
- You cannot be medically determined to have end-stage renal disease*.

How can I join a plan?

You can get the names of the coordinated care plan(s) in your area that have Medicare contracts by calling any Social Security Administration office or by calling 1-800-638-6833. All contracting HMOs and CMPs have an advertised open enrollment period of at least 30 days once a year.

Before you join an HMO or CMP, be sure to read the plan's membership materials carefully to learn your rights and the nature and extent of your coverage. And if you live in an area served by more than one plan, compare costs and other features to determine which plan best suits your needs at a price you can afford. Plans use different doctors and hospitals, charge different premiums, and have different administrative policies.

*If you choose hospice care after joining a coordinated care plan, you will receive hospice services from a Medicare-approved hospice, but you may, if you wish, continue your enrollment in the plan. If you do, the plan is required to continue to provide or arrange for all care unrelated to the terminal condition. Also, if after joining a plan you are medically determined to have end-stage renal disease, the plan is required to provide or arrange for your care.

If I enroll, where do I go for care?

Most plans that contract with Medicare have "risk" contracts which contain "lock-in" provisions. Under this arrangement, Medicare pays the plan a pre-determined monthly sum to provide you health care services, and the plan assumes the financial risk of providing those services. If you enroll in one of these plans, you are locked into receiving all covered care from the plan, except for emergencies or urgently needed care away from the plan's service area. If you go outside the plan for unauthorized care, neither the plan nor Medicare will pay.

Besides risk-contracts, some plans have "cost" contracts with Medicare. These plans are paid a fee by Medicare to provide you with hospital and medical services. If the plan provides more services than what the fee covers, Medicare reimburses the plan the difference at the end of year. In a cost-contract plan, you are not locked into receiving services from the plan. While the plan will not pay if you use non-plan providers, Medicare will still pay its share for covered services. In such instances, you would be responsible for paying Medicare's copayments, deductibles and other permissible charges, just as if you were receiving care under the traditional fee-for-service system.

In addition to its risk- and cost-contract plans, Medicare has agreements with health care prepayment plans (HCPPs). They are unlike the other plans in that they only partially cover Medicare benefits. Some HCPPs cover all Part B benefits and others cover only some of them. Although HCPPs do not cover Medicare Part A services, some arrange such

services and may file Part A claims on your behalf. Medicare enrollees in HCPPs can go outside the plan for any medical or hospital services. You should be aware that an HCPP may have enrollment requirements and other rules that are different than those of risk- and cost-contract plans.

Will I always have the same doctor?

When you enroll, most coordinated care plans allow you to select a primary care doctor from those affiliated with the plan. If you do not make a selection, a primary care doctor will be assigned to you. Primary care doctors are responsible for managing their patients' medical care and admitting them to a hospital. All health services are obtained through your designated primary care doctor. If for any reason you want to change your primary care doctor, the plan generally will let you do so as long as you pick another one of the plan's primary care doctors.

What about specialists and hospital care?

Coordinated care plans use a full assortment of specialists. Usually, you must be referred to a specialist by your primary care physician if the plan is to cover the specialist's services. And just as a plan arranges in advance with specific doctors to care for members, it generally has contracts with specific hospitals, skilled nursing facilities, home health care agencies and other health care providers to

serve its members. Some of the larger plans have their own hospitals and other health care facilities. In most cases plan members must use those designated providers or the plan will not pay for the care.

What if the coordinated care plan refuses to pay for medically necessary care?

If a plan refuses to pay for or provide medically necessary covered services, and you believe it should pay for or provide the services, you have guaranteed appeal rights under the Medicare law. These rights are explained in the health plan's description of its benefits and coverage.

What if I am not satisfied with the care I receive?

If you are dissatisfied with the quality of care provided, you can:

- follow your plan's grievance procedure,
- write, or in some cases, call, your Peer Review Organization (PRO)*, *or*
- disenroll at any time, effective the following month.

How do I get out of a plan?

If you enroll in a plan and later decide to return to fee-for-service Medicare coverage, you may disenroll at any time, effective the first day of the following month. To disenroll,

*PROs are groups of practicing doctors and other health care professionals under contract to Medicare to review the care provided to Medicare patients. They are listed in The Medicare Handbook.

all you need to do is state in writing that you want to withdraw from the plan and return to traditional Medicare coverage. Give the written statement either to the plan's administrative office or to your local Social Security Administration or Railroad Retirement Board office. Your coverage under the fee-for-service system will begin the first day of the following month. If you want to change from one plan to another, you may do so by simply enrolling in the other plan as long as it has a Medicare contract. You are automatically disenrolled from the first plan.

Medicare SELECT available in certain States

Medicare SELECT is a Medigap insurance product that may be available in designated states through either HMOs or insurance companies. The States where these policies are currently authorized to be sold are Alabama, Arizona, California, Florida, Indiana, Kentucky, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington and Wisconsin.

If you buy a Medicare SELECT policy, you are buying a Medigap policy. The only difference between Medicare SELECT and standard Medigap insurance is that Medicare SELECT policies will only pay full supplemental benefits if covered services are obtained through specified health care professionals. Medicare SELECT policies are expected to have lower premiums because of this limitation. The specified health care professionals, called "preferred providers," are selected by the insurance company or HMO. Each issuer of a Medicare SELECT policy makes arrangements with its own network of preferred providers.

If you have a Medicare SELECT policy, each time you receive covered services from a preferred provider, Medicare will pay its share of the approved charges and the insurer will pay the full supplemental benefits provided for in the policy. Medicare SELECT insurers must also pay supplemental benefits for emergency health care furnished by providers outside the preferred provider network. In general, Medicare SELECT policies deny payment or pay less than the full benefit if you go outside the network for non-emergency services. Medicare, however, will still pay its share of approved charges in such situations.

Medicare SELECT will be evaluated through 1994 to determine if it should be made available throughout the nation. Companies selling Medicare SELECT policies are required to provide for the continuation of coverage if the policies are discontinued. If the program is not extended, Medicare SELECT policyholders will have the option to purchase any standard Medigap policy that the insurance company or HMO offers, if in fact it issues Medigap insurance other than Medicare SELECT. To the extent possible, the replacement policy would have to provide similar benefits.

For More Information About Medicare

For more information about the Medicare program, please refer to The Medicare Handbook. Free copies are available from any Social Security office.

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